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High Hopes for medical cannabis: Learning from the United States policy regulation to inform the European Union policy development

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1. Introduction

Cannabis is classified as a drug in countries across the globe. Hitherto the UN Vienna Conventions in 1961 on drugs, countries each possessed their management of drugs, and after the convention, the war on drugs was declared. Consequentially, cannabis became illicit and its benefits as a medicine were abandoned (Gardiner et al., 2019). Only decades after the war on drugs had been announced medical cannabis became a topic of interest again. Contrary to the previous climate surrounding the regulations of drugs, developing, and researching medical cannabis has become tremendously harder. Most countries have banned any usage of cannabis for health or recreational purposes, making the conduct of experiments or trials on its benefits overly complex. Over time and with perseverance science proved the benefit of using cannabis as a medicine and some countries such as Canada, Israel and the Netherlands legalised its use. However, for governments, the conundrum of regulating medical cannabis has not gotten simpler. Governments are faced with the struggles of potential harm medical cannabis causes to public health compared to the benefit it can offer to health (Fijnaut & Ruyver, 2015). Additionally, regulation on the topic was neglected for many years leading to regions and provinces creating their own regulations and resulting in large disparities between states of the same country or countries of the same regional organisation (Carlini et al., 2017; Hallinan & Bonomo, 2022; Veit, 2023). This disparity poses a threat to correct and effective regulations on research and use of medical cannabis. Nonetheless, in some cases, this obstacle was overcome. In 2022, both the House of Representatives and the Senate of the United States (US) passed the Cannabis Research Bill. The bill aims to create a country-wide framework to facilitate medical research on cannabis as well as its manufacturing and transportation directives. Australia solved a similar issue of discrepancies between provinces especially in the delivery of medical cannabis by introducing a country-wide internet platform two years after legalising its use. In terms of regional organisations, less progress in creating homogenous regulations has been achieved. The European Union suffers greatly from the lack of consensus on medical cannabis with some Member States (MS) having legalised it, some partially approved it and others repressing it. This heterogeneity in the European context produces increased complexity for cross-border healthcare and control and it limits research and knowledge from arising from cooperation between MS. By setting the case of the US and the EU side by side, the US emerges as a precursor in attempting to set uniform medical cannabis regulations. Therefore, focusing and researching the US context of legalisation and regulation of medical cannabis can inform the case of discrepancies in the EU.

To conduct this research, a review of the existing literature is provided. Through the literature, an assessment of knowledge of regulations of medical cannabis in the US and the EU is made and a gap in the knowledge is revealed. To fill this gap, two frameworks are used in the theoretical framework – the Multiple Stream framework and the Advocacy Coalition framework. The method selected to conduct this research is a case study where policy documents are the data analysed. The analysis offers an in-depth description of each case, and the discussion connects the findings of each case together and to the grander context. The conclusion provides a direct answer to the research question and raises important societal implications for the EU through the US findings.

2. Literature review

2.1 Medical cannabis and its regulations

Research focusing on the potential benefit of medical cannabis on overall health is to a certain degree always interconnected to regulations. Therefore, the theme of policy and regulations of medical cannabis is an important and debated topic within academia. Moreover, different approaches to regulations are discussed. For instance, medical cannabis can be regulated like other drugs society has deemed acceptable such as alcohol and tobacco (Shover & Humphreys, 2019). Learning from alcohol or tobacco regulations offers a starting point for regulating medical cannabis and prevents policymakers from repeating past mistakes. However, regulating cannabis as such also negates its paradox. Cannabis can be a dangerous drug, but it does not prevent it from having real health benefits (Haroutounian et al., 2016). Thus, it appears to be too simplistic to draw inspiration from alcohol or tobacco to regulate medicinal cannabis.

A different approach traces the evolution of cannabis policy in various European Union MS and focuses on the intertwined legalisation of medical cannabis and recreational cannabis (Fijnaut & Ruyver, 2015). This article explores the case of Germany legalising cannabis, and its portrayal as a threat to public health (Fijnaut & Ruyver, 2015). This ties back to the paradox of medical cannabis, correctly regulated by policymakers' medical cannabis represents hope and a solution for the population, nonetheless, wrongly regulated medical cannabis represents a threat to public health. To overcome this paradox and determine the correct way to regulate medical cannabis, Schlag (2020) offers to review six countries that have legalised medical

cannabis. In this evaluation, the author aims to review and compare different ways to regulate medical cannabis to best advise the United Kingdom on future regulations (Schlag, 2020). The article concludes countries take various approaches to regulate medical cannabis, but some important aspects of regulating medical cannabis are pointed out. Most importantly regulations should be not too strict or too wide, continuous education for health providers is needed, and communication between physicians, patients and policymakers is essential (Schlag, 2020). These facts established, it is mentioned that no ideal approach to regulating medical cannabis is displayed but only guidelines for the United Kingdom to make informed decisions and choices.

Connecting and synthesizing the literature on the regulation of medical cannabis highlights a lack of common consensus on the correct manner to approach the topic and how to overcome its obstacles. The lack of common consensus in the literature is connected to the current reality policymakers, physicians and patients are faced with when it comes to medical cannabis. As stated in the introduction in some cases such as the US and Australia the first obstacles have been subdued but in other cases such as the EU and the United Kingdom knowledge from already established states might be beneficial.

2.2 Medical cannabis and its regulations in the European Union

Within the EU, MS are free to individually regulate medical cannabis. Medical cannabis falls under the category of health which is a topic the EU formally does not have competencies over. However, because of the EU's interconnectedness and its growing supranationalism, the topic of health has informally entered the EU's arena (Greer, 2021). Thus, by selecting the EU as a unit of analysis for medical cannabis some debates and consensus arise on the challenge of regulations.

First, all researchers agree on the urgent need for a common regulation of medical cannabis in the EU (Lipnik-Štangelj & Razinger, 2020; Fijnaut & Ruyver, 2015; Abuhasira et al., 2018; Veit, 2023). Although their research focuses on various topics the conclusion always seems to be calling for EU-wide policies. This overwhelming consensus of the literature on the need for common regulations instinctively poses the question of why this framework currently does not exist. Some hypotheses are mentioned but no clear answers are provided. Lipnik-Štangelj & Razinger (2020) propose historical and cultural differences as a potential explanation. Another article focusing on drug policy alludes to MS not being interested in legalising any form of drugs. Their disinterest in legalising drugs would arise from the complexity of controlling

borders and thus, not wanting to change the current status quo. This wish to maintain the current border control policy would prevent any dialogue from the EU level (Fijnaut & Ruyver, 2015). However, this explanation seems insufficient to understand the climate surrounding medical cannabis because the EU does challenge its status quo surrounding border policy. Consequentially, these potential hypotheses for the current lack of EU common regulations offer a starting point for further research but remain inadequate to correctly understand the case of medical cannabis regulation in the EU.

In addition to reviewing the literature, the current state of medical cannabis regulation in the EU was explained. It specifically uncovered the complexity of EU regulations and their malfunctioning. In order, to convey a clear picture of these regulations *Figure 1.1* based on Veit's (2023) and Lipnik-Štangelj & Razinger's (2020) articles is provided. This figure aims to point out where the current regulations produce discrepancies between and within MS.

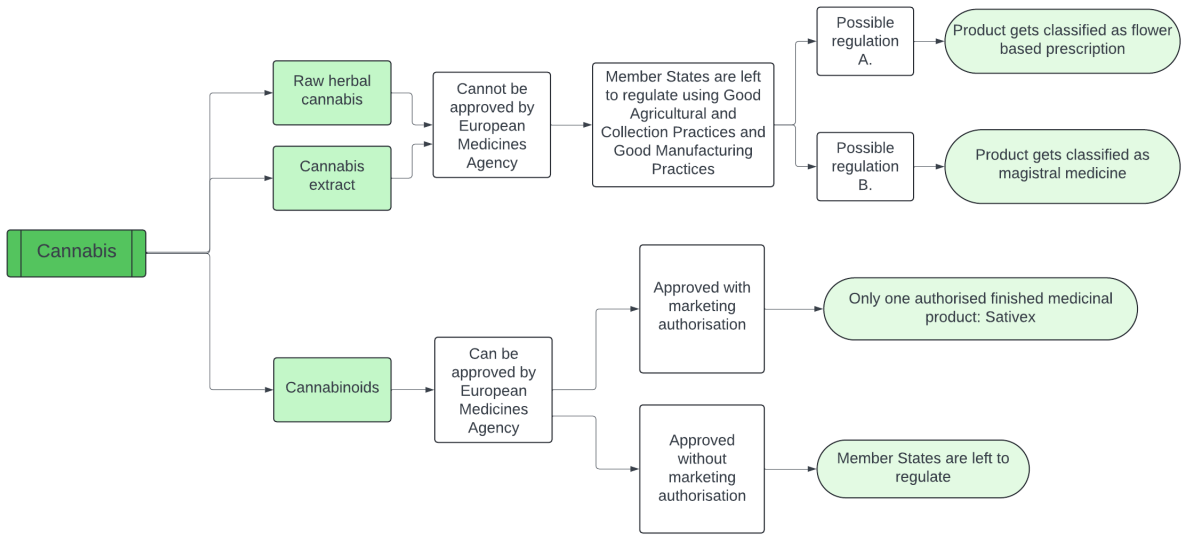

Figure 1.1 Overview of the current European Union's regulation of medical cannabis based on Veit (2023) and Lipnik-Štangelj & Razinger (2020)

2.3 Medical cannabis and its regulations in the US

The American literature on medical cannabis and its regulations share some commonalities with the literature on the EU but also reveals different approaches and debates. Most research exploring the topic of medical cannabis takes the form of a review of current legislation (Jameson et al., 2022; Donahue et al., 2023; Perlman et al., 2021; Mead, 2017). The conformity of this approach reveals how affected the research field is by the lack of common regulations of medical cannabis in the US. All reviews implore the federal government to change the status

of cannabis and to remove it from Schedule I. Drugs on Schedule I are classified as highly dangerous and thus cannot be approved by the Food and Drug Administration for any medical use. Throughout the articles calling for an urgent need to change the current laws, various implications due to the lack of regulations are mentioned. Three categories can be distinguished from the different concerns researchers raise. First, the lack of research is the most prominent reason for the need for common regulations to be established, without removing cannabis from Schedule I, proper and effective research cannot be conducted (Schauer et al., 2023; Gladden et al., 2020; Donahue et al., 2023; Perlman et al., 2021). The second concern revolves around health, especially for patients and health providers/carers (Schauer et al., 2023; Gladden et al., 2020; Donahue et al., 2023; Perlman et al., 2021). The third reason revolves around regulating the market and the impact of taxes on the legalisation of cannabis as well as its impact on patients' behaviour (Schauer et al., 2023; Perlman et al., 2021). This third reason has not been evoked in the literature focusing on the EU, potential explanations for this is the lesser advancement of the EU in creating a common EU-wide framework. Other concerns such as the impact on public health, road safety, manufacturing practices and racial inequality were mentioned as further reasons to create medical cannabis regulations at a federal level (Jameson et al., 2022; Perlman et al., 2021).

Moreover, in one article the 2022 Cannabis Research Bill was briefly referred to. The rapid assessment of the Bill was concluded by acknowledging it as a step in the right direction but remaining realistic on the fact that cannabis remains on Schedule I (Donahue et al., 2023). The over-extensive reviews of the regulations in the literature allow for a crystal clear depicture of the current landscape and steps needed to be taken to overcome this obstacle. However, no research has focused more closely on potential hypotheses explaining the lack of actions taken by the federal government to create common regulations before 2022. The lack of more precise policy process research in medical cannabis is not surprising. Public health-related policy research struggles to embed itself in policy process methods and theories (Greer et al., 2018).

2.4 Filling the gap

Having discussed the literature on medical cannabis and its regulations, it appears no consensus has been built on how to correctly approach the puzzle of medical cannabis and its regulations. Potential explanation for the lack of consensus is mentioned in the case of the EU and extensive reviews of current legislation are conducted in the US. Nonetheless, little attention was given to the policy-making process and trying to understand its functioning for the topic of medical cannabis. Therefore, focusing research on understanding the policy process of medical

cannabis in the US is a significant step forward. This research aims to provide answers for the lack of response from the federal government concerning the demands for a common regulatory framework and it aims to contribute to the case of the EU by analysing potential policy processes to establish. This approach of reviewing a certain case to inform another is similar to Schlag's (2020) approach. Therefore, using the case of the US to inform the EU, the following research question is proposed: *what are the driving and restraining forces which led the US to take a step forward into establishing a common regulatory framework of medical cannabis?*

3. Theoretical framework

To understand the process of medical cannabis policymaking two frameworks are used to capture the full policy process. The first theory, the Multiple Streams framework focuses on the early stages of policymaking. The second theory, the Advocacy Coalition framework engages a more holistic approach by considering all stages of the policy process. Combining these two frameworks allows this research to focus on a certain stage of the policy process while still giving a clear description of the entire process. Furthermore, it draws on the strength of each framework while limiting each weakness of the respective framework.

3.1 The Multiple Streams Framework

The Multiple Streams framework is a framework based on the garbage can model of the policy process (Cohen et al., 1972). This policy process theory is defined by three independent streams which should be analysed separately from each other (Zahariadis et al., 2023). The first stream is the problem stream. It is characterised by the call for attention that a policy needs to gain importance in policymakers' eyes (Zahariadis et al., 2023). The second stream is the policy stream, which refers to the expert field working on how to improve a certain issue area, this is independent of whether the issue is considered as a problem or not (Zahariadis et al., 2023). This expert field can be various actors such as politicians, interest groups, academia, media, bureaucracy, and parties (Zahariadis et al., 2023). The last stream is the political stream composed of three elements national mood, interest group and government (Zahariadis et al., 2023). Defining these three different streams the framework argues the three streams must all be coupled together at the same time by policy entrepreneurs to lead to a policy window. Once a policy window has opened the topic can progress. Applying this framework to the case of

medical cannabis in the US gives guidance to the research on what elements to focus on and what to research.

3.2 The Advocacy Coalition Framework

The Advocacy Coalition framework adopts a different premise than the Multiple Stream framework. It recognises the complexity of public policy and the role of each actor in the policymaking process. The framework focuses on actors forming an advocacy coalition bounded by shared belief and their interaction and negotiation with other coalitions to create a new policy outcome (Sabatier, 1988). Thus, the objective of this framework is to simplify the complexity of public policy and to combine all the stages of the policy-making process (Weible et al., 2009). The framework was built around overcoming the limitations of the policy process literature, one of them being the lack of theory and research on the role of scientific and technical information in the policy process (Sabatier, 1988). The framework accounting for this limitation is relevant to the case of medical cannabis as most of its development arises at the root of the scientific field. The essence of the Advocacy Coalition framework relies on beliefs as the causal driver for political behaviour and change (Sabatier, 1988). This transition emerges from a set of assumptions notably the essential role of scientific and technical information in the policy process, a defined policy subsystem as a unit of analysis and broad actors' participation (Sabatier, 1988). Since beliefs are the casual driver for policy change, three different types of beliefs are identified - deep core beliefs, policy core beliefs and secondary aspects. Secondary aspects are related to more pragmatic beliefs usually embedded geographically and empirically, they are the most likely to change over time (Weible et al., 2009). This framework is effective in the case of medical cannabis because it manages to understand the pluralism of actors in a coalition to drive a policy change. Furthermore, it does not stop at the agenda-setting but also informs the research until the outcome of the policy process.

3.3 Combining the two frameworks and theoretical expectations

By combining the Advocacy Coalition framework and the Multiple Streams approach a more powerful and effective framework is created. This revised framework manages to clarify the nature of actors, activities and motivations at each stage and conjuncture of policymaking (Howlett et al., 2017). In essence, a better conceptualisation of the subsystem actors and their interaction is provided by the concepts of streams, windows of opportunities and critical

moments (Howlett et al., 2017). In the case of medical cannabis, it is essential to analyse and understand how the full policy process came about.

In consideration of the suitability of the Multiple Stream framework and based on the summarised hypotheses of the Advocacy Coalition Framework, the following questions will guide the analysis:

A. What are the actors in the problem, the policy and the political stream of medical cannabis and what coalition did they each form?
B. What type of belief system existed in these coalitions?
C. How did the different streams and coalitions couple at junctures?

4. Research design

4.1 Research method

To complete this research the method of a case study is used. As defined by Halperin & Heath (2020), for a case study to be interesting and relevant it needs to have a comparative dimension to it and be internally and externally valid or at least aim to be for the latter. In the case of medical cannabis in the US shedding light on how the medical cannabis policy process unravelled is essential. De facto, amongst the literature the call for policy action is urgent and desperate (Schauer et al., 2023; Gladden et al., 2020; Donahue et al., 2023; Perlman et al., 2021; Jameson et al., 2022). However, before passing any medical cannabis policy an excessive time had passed, potentially harming public health. This case study is relevant to the US as it fills the need to understand what the restraining forces behind passing medical cannabis policies are and how this could be better dealt with in the future. Moreover, this study is conducted to inform the EU. The EU must overcome the problem of establishing common regulations. Regardless of the result of the analysis, some guidance will arise, thus, fulfilling the external validity criteria. This case study is used to provide a descriptive contextualisation, it does not aim to generate new theory or test existing theory, especially given the chosen frameworks.

4.2 Case selection

The US is a federal state; thus, the two levels of government need to be considered to assess the policy process. The first level of government analysed is the federal government. The

second level of government selected is specific states. The strategy used to select certain states was based on selecting the most relevant cases to inform the theoretical interest (Seawright & Gerring, 2008). The case selection does not attempt to be representative but strives to be informative and explore the various dimensions of cases (Seawright & Gerring, 2008). The first state selected is the state of California. California is the first state in the US to have legalised the use of cannabis for medical reasons through the Compassionate Act of 1996. Analysing California is essential to understanding the evolution of medical cannabis across time and its positions towards the federal government. California is considered a special and extreme case and a leader in regulating and progressing medical cannabis. The second state analysed is the state of Pennsylvania. Pennsylvania legalised medical cannabis in 2016, thus representing an "average" case. Most US states legalised medical cannabis between 2015 and 2019. The third state selected is the state of South Carolina. South Carolina does not have legal or decriminalised medical cannabis. This case stands for the minority of US states not having legalised medical cannabis. With these three states, the research provides the array of diversity needed to collect enough theoretical interests. Analysed together the cases of California, Pennsylvania, and South Carolina account for the largest disparities in medical cannabis regulations within the US, respectively standing for an early onset case, an average case and a late case.

4.3 Data Selection

To analyse each case, the type of data selected is policy documents. In the case of the federal government the website "Congress.gov" was used to access the transcripts of the bills. To find relevant bills the words "medical" and "cannabis" were typed in the search bar and the box "legislation" was ticked to confirm only suitable documents would appear. No timeline was applied, and all relevant policy documents which fit those criteria were considered. In the case of California, a similar method was used. The website "leginfo.legislature.ca.gov" provided the transcripts. The terms "medical", "marihuana", "marijuana", and "cannabis" were typed in the search bar and all relevant bills mentioning these words were analysed. Once again, no timeline was applied, the earliest to the latest documents were considered. In the case of Pennsylvania, the website "legi.state.pa.us" was used. To find all relevant policy documents the words "medical" and "cannabis" were typed in the search bar and all years were selected. In the case of South Carolina, the website used was "scstatehouse.gov" and similarly to other cases, the words "medical", "cannabis" and "marijuana" were entered in the search bar.

The only type of data used for this research is policy documents as the objective is to understand the formal policy process and its driving and restraining forces. By only looking at policy documents, elements such as coalitions, belief systems and the actors involved can better be captured. Moreover, the case of the US was selected because of its advancement in creating a common regulatory medical cannabis framework. This advancement can only be accounted for by analysing the bills formally introduced and observing how medical cannabis embeds itself in the policymaking process.

5. Analysis

The analysis of the federal government and the three selected states reveals different patterns of policy change. The federal government displays an overwhelming presence of the legal burden of cannabis on regulating its medical use. California exhibits a timeline of the evolution of creating medical cannabis which is useful to prevent the repeat of past mistakes. The second state, Pennsylvania offers an in-depth understanding of a successful policy change process in legalising medical cannabis. The state of South Carolina manifests a hopeful policy change process to be taken in the future.

5.1 The case of the US federal government

The analysis of the US federal government policy documents provides some answers to the questions established in the theoretical framework. More precisely in understanding how the topic of medical cannabis develops throughout time in the House of Representatives and the Senate and couples with which actors.

The earliest policy document mentioning medical cannabis was published in 1995. This bill aimed to allow the provision of cannabis for extreme cases of medicine. It referred to the Subcommittee on Crime and on Health and Environment. After this bill up until 2013 no bills were found mentioning medical cannabis, the reason for this is unconfirmed. Although, it is most likely the issue had simply never reached the bill-writing stage. When inspecting the timeline, 2018 and 2019 are found to have the most bills concerning medical cannabis. In 2020, only two bills mentioned medical cannabis, yet, in 2021 the frequency increased again. The timeline is interpreted as the topic of medical cannabis is a growing issue for the federal government, but this progress was slowed down by the COVID-19 crisis and put on hold.

Following the framework established in the theoretical framework attention is paid to the actors involved in medical cannabis-related bills. Almost all bills involved the Committee on the Judiciary which refers to the Subcommittee on Crime, Terrorism, and Homeland Security in compilation with the Committee on Energy and Commerce referring to the Subcommittee on Health. The involvement of the Subcommittee on Crime reveals the nature of the problem of medical cannabis. Cannabis regardless of its usage is a drug and is criminalised, thus, any attempt to challenge the status quo through a bill is first faced with the Judiciary. This impression is even more reinforced by the policy area defined by the federal government. The most common policy area concerning medical cannabis bills is referred to as "Crime and Law Enforcement". Regardless of the content of the bill, research, access or development of medical cannabis, most bills' policy area is Crime and Law Enforcement. Only four bills out of fifty-two have "Health" as a policy area. The implications of this framing are major, it reveals the reluctance of the federal government to consider cannabis as a benefit and an asset for health.

Most bills are introduced by the House of Representatives and the Senate comes second in introducing bills on the topic. Another finding that appears when analysing the federal government's policy documents is through which means the subject of medical cannabis arises, it arose through the health of veterans. In 2018 a bill to authorise research on the efficacy and safety of medical cannabis for veterans was introduced. This bill was brought up by the Committee on Veterans Affairs referring to the Subcommittee on Health, the policy area defined was "Armed Forced and National Security". After this medical cannabis bill for veterans was introduced, the bills presented to the House and the Senate got progressively more concrete in terms of policy goals. For instance, shortly after in 2018, a bill mentioned the current barriers to medical cannabis due to current federal law, this is discussed in the context of ensuring accessibility of medical cannabis for veterans. Moreover, it was in 2019 two bills one from the Senate and one from the House requested for cannabis to be removed from Schedule I to Schedule III. Cannabis being classified as a Schedule III drug would make research, manufacturing, and accessibility much easier for medical purposes. These bills are a testament to the awareness of the federal government concerning cannabis being classified as Schedule I, despite that neither of these bills were passed. It is still an encouraging sign that both the House and Senate wrote a similar bill. Withal, on actors of medical cannabis, a few bills involved a multiplicity of actors such as the Committee on Judiciary, Agriculture, Natural Resources, Energy and Commerce and Small Business. This larger coalition recognised the

obstacles present at every dimension of medical cannabis, and acknowledged the hardship undergone by advocates of medical cannabis because of the declared "War on Drugs".

5.2 The case of California

In the case of California, a hundred and thirty-one policy documents were analysed. The first bill available online dates from 1999 and established a three-year research program to ensure the safety of using medical cannabis after California legalised medical cannabis in 1996 with the Compassionate Use Act. The most medical cannabis-related bills produced within a year happened in 2016 with eighteen bills and in 2018 with seventeen bills. There is no recognised pattern of bill frequency with years and the frequencies do not formally line up with the federal government's production of medical cannabis-related bills. The committees producing the bills are also not disclosed so no information is comparable to committees used at the federal level.

Chronologically the content of policy documents progress as follows, as soon as the year 2000, California called for the federal government to urgently create a safe and affordable plan to distribute medical cannabis. Thus, California formally requested help and guidance. In 2003, California reiterated its need for action from Congress and the President in rescheduling cannabis. They also mention the threat caregivers and patients are faced with under federal law. After this bill, California did not reiterate its need for help from the federal government until 2008 when they urged Congress and the President to stop seizing medical cannabis dispensaries and to finally respect the Compassionate Use Act. This is followed by a bill formally stating California will refuse to assist the federal government in raiding medical cannabis dispensaries. In 2009, California denounced the federal government's aggressive behaviour towards medical cannabis and pointed out its refusal to provide states with guidelines to follow. In 2011, California stated the lack of evidence the federal government possesses in proving dispensaries are evading tax and providing illicit non-medical cannabis to the population. To end all potential debate, California decided to take action and created a task force to counter this illicit market. After five years of not mentioning the federal government, California attempted to create federal regulation for the cultivation of medical cannabis. De facto, the state realised the impact of medical cannabis cultivation on the environment. Medical cannabis cultivation regulations impacted water quality, especially concerning fish and wildlife. In the same year, the state vouched for the protection of businesses abiding by taxes in relation to medical cannabis. The state provided an incentive to start abiding by tax laws and minimised the fear of the federal government by offering protection. In 2018, California reiterated its call for the US Department of Justice to not direct its energy towards the lawful and regulated medical

cannabis industry but instead to focus on the opioid crisis taking place in the country. Similarly, the state of California requested formally the President and Congress to reschedule cannabis and mentioned the hardship of researching and setting up financial systems for medical cannabis-related businesses. Moreover, the same year another task force is created to protect the legal use of medical cannabis and to eradicate the illicit market. In 2019, California launched a policy with an incentive for veterans to buy from the legal cannabis market, potentially related to the federal government addressing the issue of medical cannabis through veterans. After 2019, no bill summoned the federal government to act on the topic of medical cannabis. The description of this timeline is relevant for comprehending the relationship between the two levels of government. The federal government started as a potential ally and transformed into an enemy. This transformation can be explained by the established framework. The federal government and the state of California do not have corresponding types of beliefs. California's policy core beliefs are not considered or acknowledged by the federal government because its own deep core beliefs prevent it from evolving. The classification of cannabis as a Schedule I drug is a deep core belief of the federal government. From this deep core belief limited conversation about policy core beliefs of California can be held. This explains the difficulty in forming a coalition and coupling up at a juncture, under the current conditions the federal government and the state of California are de-aligned.

Moreover, the state of California in dealing with medical cannabis is surrounded by many secondary aspects. In virtue of them being the first state to legalise medical cannabis, they are burdened by resolving how to provide safe medical cannabis for the population. For instance, over time, issues such as taxation, environmental protection, financial system, licensing, employment discrimination and pupil protection all had to be addressed and arose from the problem stream. These technical matters create an overload of secondary beliefs which the federal government finds themselves even more de-aligned with as their deep core belief is such at an earlier stage of creating medical cannabis policy.

5.3 The case of Pennsylvania

In the case of Pennsylvania, nineteen policy documents were analysed, the first policy document addressing medical cannabis was introduced in 2014 and the last policy document was introduced in 2023. In 2019, four medical cannabis policy documents were introduced which makes it the year with the most medical cannabis-related policy produced. The Compassionate Use of Medical Cannabis Act was the first bill attempting to introduce medical cannabis in 2014. With this bill, an advisory council would be created. It would be composed

of various actors involved in medical cannabis – health actors, agriculture, drug and alcohol programs, and patient protection. This bill encompassed many issues in regulating medical cannabis which implies a maturity of the policy stream. In 2016, medical cannabis became legal in Pennsylvania through the Medical Marijuana Act. This bill stated the removal of cannabis as a Schedule I drug under state law and as previously introduced in 2014 the bill remains all-encompassing. For instance, the long title of the bill addressed taxation, research, education, sanctions, and registration. After medical cannabis was legalised, minor amendments were made to facilitate technical matters. However, in 2019 Pennsylvania urged the President and Congress to remove barriers from financial institutions to facilitate cannabis-related businesses to operate under state law. The state of California had issued a similar bill also urging the federal government for action. This parallel reinforces the difference in beliefs between states having legalised medical cannabis and the federal government. States with legal medical cannabis root their demands in policy core beliefs and secondary aspects. On the contrary, the federal government's policy is rooted in deep core beliefs. Consequently, all states such as Pennsylvania and California having legalised medical cannabis are faced with secondary aspect issues that cannot be accounted for by the federal government regardless of the time frame in which these states make medical cannabis legal.

Furthermore, the case of Pennsylvania gives examples of various policy issues surrounding medical cannabis that had not been answered before. First, Pennsylvania formally requested Congress and the President in 2018 to amend the Gun Control Act of 1968 to protect the constitutional rights of medical cannabis users. As trivial or inconsequential as this request might appear, it roots the issue of medical cannabis within a grander context and highlights its impact on a multitude of existing norms. In addition to this realisation, in 2023 a bill urging the Department of Health to investigate the ties of medical cannabis business to Russian business is introduced. This bill arose after the invasion of Ukraine by Russia in solidarity with Ukraine. Once again, this bill embedded the topic of medical cannabis in a real-world context instead of treating the issue as a solely judiciary and health-related matter. Furthermore, this reasoning highlights the need for advocacy coalitions in policy making, medical cannabis as a policy cannot be fed solely by health advocates it needs to exist in a larger context to develop.

5.4 The case of South Carolina

In the case of South Carolina (SC) twelve policy documents ranging from 2014 to 2024 were analysed, no previous policy documents were found for this case. The first bill was introduced in 2014 by the Judiciary and Medical Affairs. It allowed patients to enter a medical cannabis

research program and be protected by the state. After this bill, the SC Compassionate Care Act was introduced in 2017, 2019, 2021, 2022, 2023 and in 2024. Each of these bills modelled each other with minor amendments made. For instance, each bill stated the number of states allowing medical cannabis in their territory, in 2017 it declared twenty-nine states have approved medical cannabis and in 2024 the number has gone up to thirty-seven states. This is an indication of the growing trend of legalising medical cannabis through state law and it provides a sense of urgency in passing this bill for the improvement of SC. Furthermore, the policy document attempting to establish medical cannabis appeared to have created a juncture between the policy stream and the problem stream. De facto, the first version of the Compassionate Care Act addressed almost all technical matters surrounding the regulation of medical cannabis such as licenses, taxation, environmental control, dispensaries, and employment discrimination. Furthermore, it stated the US acceptance of the use of cannabis for medical matters and listed different organisations and research vouching for its benefit. However, the third stream needed to pass this bill, the political stream was not present. This implies that regardless of the advocacy coalition entertained by the policy and the problem stream without the issue seen as relevant and important no policy can erect. This theory is further confirmed by the bill the Medical Marijuana Referendum introduced in 2023. This bill introduced by Medical Affairs proposes a statewide advisory referendum at the same time as the 2024 elections asking the population whether medical cannabis should be made legal in the state of SC. Following the theoretical framework established, this is the most effective solution to pass on the SC Compassionate Care Act as this referendum represents the political stream missing from the current climate. Through this referendum, the three streams would finally couple at the juncture and allow for the passing of the bill.

6. Discussion

The discussion answers the research question by pointing out the restraining and driving forces which arise from the analysis. Two interlinked restraining forces are identified at the level of the federal government and one main driving force is erected at the state level.

Focusing on the actors present in each case and what coalition they formed explained the restraining forces present in creating a common regulatory medical cannabis framework. The policy area defined at the federal government's level, and the Committee called upon is Crime and law enforcement and the Judiciary. The main discourse surrounding cannabis is not

whether it is beneficial for health but whether it is legal, this leads to a restraining force upon creating effective regulation. The federal government exhausts itself around legal struggles and does not approach the subject from a scientific and medical perspective. In the existing literature, this restraining force is a central motive. Nonetheless, the impact it has on the federal level of government has not been formally acknowledged in the literature. Instead, it is currently portrayed as imposed upon states. Yet the analysis reveals the federal government is itself burdened by this classification of cannabis.

Furthermore, analysing the actors surrounding medical cannabis regulation underlines the importance of having a strong coalition. For instance, the legalisation of medical cannabis in California happened extremely early on and based solely on health benefits, this led to unaddressed issues surrounding the whole industry of medical cannabis. These issues over time have been addressed and accounted for, though, they all had to mature to a certain stage before being resolved. On the contrary in the case of Pennsylvania, a large multi-disciplinary coalition was formed around the regulation of cannabis creating a stronger framework and less chance of an illicit market to arise parallelly. From the analysis of the various states policy documents, it is evident that large and multi-disciplinary coalitions need to be present for successful medical cannabis regulation. These pointers on how to regulate most effectively were touched upon in previous literature but some important actors were neglected. For instance, the problem of different manufacturing regulations is raised but the struggle for environment protection was never mentioned. These findings point to the fact that a driving force behind successful medical cannabis regulations is having large coalitions of actors and not only relying on the scientific and medical aspects of cannabis for health.

Utilising the streams in the state cases allowed some driving and restraining forces to be spotted. In the state of South Carolina where medical cannabis is not yet legal, the political stream is the one at an immature stage not ready to couple with the problem and the policy stream. As stated in the policy documents, the need and the knowledge surrounding medical cannabis and its regulation exists within the population and policymakers. The former is representing the problem stream, and the latter is representing the policy stream. Nonetheless, it appears the topic of medical cannabis is not political enough for the stream to join forces. Comparing the dynamics of this state to the dynamic of the federal government a different stream is missing. The federal government has a mature political and problem stream. However, the policy stream is restrained by the focus on the legal matter surrounding cannabis and its existence as a drug. These findings reinforce the restraining force mentioned above, the

discourse surrounding medical cannabis is burdened by legal matters preventing potential progress. The case of South Carolina illustrates a more hopeful policy process, the driving force behind legalising medical cannabis is its need and recognised benefits, the issue simply needs more time to gain popularity and salience.

Analysing the states and the federal government led to the discovery of different belief systems. The states through their policy documents address majoritarily secondary aspects of medical cannabis. Secondary aspects beliefs are identified as they can easily be changed and usually rely on empirical or technical matters. The states also present a set of policy core beliefs such as accessibility of medical cannabis and protection of patients and caregivers but most of their bills do not transpire strong deep core beliefs. In contrast, the federal government expresses mainly deep core beliefs on the matter of medical cannabis. Their deep core belief can be seen through their reminder of cannabis as a Schedule I drug which then limits any potential shifts in their policy core beliefs or their secondary aspects beliefs surrounding medical cannabis. One of the federal government's deep core beliefs revolves around research and producing knowledge which explains the passing of the Cannabis Research Bill, nonetheless, removing cannabis as a Schedule I drug would challenge their deep core beliefs too intensely. Through this analysis another restraining force is identified, the deep core beliefs of the federal government are limiting the common regulation of medical cannabis in the US. Through the states, it is evident that coalitions based on policy core beliefs and secondary aspects beliefs manage to evolve and adapt themselves to create a common regulation of medical cannabis. On the contrary, the federal government fails to organise coalitions rooted in policy core beliefs and secondary aspects.

7. Conclusion

The US policy documents of the federal government and of the states of California, Pennsylvania and South Carolina identified some restraining and driving forces. The first restraining force revealed is the deep core beliefs of the federal government. The federal government is burdened by its deep core belief of maintaining cannabis as a Schedule I drug, thus, limiting any policy core beliefs or secondary aspects from evolving. The second restraining force recognised is interconnected to the first one, the policy stream of medical cannabis at the federal level is not mature enough to be coupled with the policy and problem stream. Consequentially, a missing stream leads to a lack of policy window and an absence of

a common regulatory framework. The driving forces which arise from this research were found in the states' cases. The main driving force behind common medical cannabis regulation is a strong coalition with a multitude of sectors and fields embedded in the policy. It is a mistake to assume science is strong enough by itself to push policy change for accessible medical cannabis. However, creating policies which encompass all aspects of creating a safe and regulated medical cannabis market increases its chance of success.

These findings have academic implications. As limited to the context as the findings are, they offer a different perspective of looking at medical cannabis. Medical cannabis within political science struggles to reflect on the progress within policy-making that has been achieved. This research provides a reflection of the evolution of medical cannabis within the US by understanding what reaches the policy proposal stage and by evaluating it. The scope of this study is limited by its data selection, only policy documents are analysed. Further research could conduct a similar study with different data selections and thus evaluate a different stage of policymaking. For instance, newspapers or speeches could be used to investigate the agenda-setting stage or surveys and interviews of healthcare providers could be conducted to research the policy implementation stage.

The case of the US was selected for its advancement in regulating medical cannabis compared to the EU. From this analysis, societal implications can be acknowledged. For the EU to create an effective common regulatory medical cannabis framework, countries should build multi-disciplinary coalitions and not solely rely on scientific and medical actors. Moreover, modelling the South Carolina case, the coalition’s energy should focus on developing their policy core beliefs and not root itself in deep core beliefs. In this process, there is hope that the policy and the problem stream will have matured enough, and the political stream will eventually arise through salience. This policy change will not be easy for the EU, yet, in comparison to the US and the deadlock of the policy stream at the federal government’s level, the obstacles to overcome appear as minor. It is important to recognise the EU is a supranational regional organisation and not a country which also entails different problems and deadlocks. Nonetheless, it is not irrelevant to study the case of the US to inform the EU. Many researchers have argued in favour of this approach (Greer, 2021; Fabbrini, 2005; Vollaard et al., 2016). Furthermore, creativity in political science is intrinsic to its development and well-being.

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